

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155570	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  03/16/2016
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NAME OF PROVIDER OR SUPPLIER  PLEASANT VIEW LODGE	STREET ADDRESS, CITY, STATE, ZIP CODE 7476 W LANE RD MC CORDSVILLE, IN 46055
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F 0000  Bldg. 00	<p>This visit was for the Investigation of Complaint number IN00194866.</p> <p>Complaint Number IN00194866-Substantiated. Deficiencies related to the allegations are cited at F155, F157, F281 and F514.</p> <p>Survey dates: March 15, and 16, 2016</p> <p>Facility number: 000477 Provider number: 155570 AIM number: 100290860</p> <p>Census bed type: SNF/NF: 30 Total: 30</p> <p>Census payor type: Medicare: 3 Medicaid: 22 Other: 5 Total: 30</p> <p>Sample: 3</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2-3.1.</p> <p>QR completed on March 18, 2016 by</p>	F 0000	The creation and submission of this plan of correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation. This provider respectfully requests that 2567 plan of correction be considered the letter of credible allegation and requests a post survey paper compliance review on or after April 11, 2016.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 0155 SS=D Bldg. 00	<p>17934.</p> <p>483.10(b)(4) RIGHT TO REFUSE; FORMULATE ADVANCE DIRECTIVES The resident has the right to refuse treatment, to refuse to participate in experimental research, and to formulate an advance directive as specified in paragraph (8) of this section.</p> <p>The facility must comply with the requirements specified in subpart I of part 489 of this chapter related to maintaining written policies and procedures regarding advance directives. These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the individual's option, formulate an advance directive. This includes a written description of the facility's policies to implement advance directives and applicable State law.</p> <p>Based on interview and record review, the facility failed ensure advance directive policy had been implemented for 1 of 3 residents reviewed for advance directives in a sample of three (Resident #D)</p> <p>Findings include:  Resident #D's record was reviewed 3-15-2016 at 3:14 PM. Resident #D's</p>			F 0155	<p><b>**The facility self-reported this complaint to Indiana State Department of Health prior to this survey on March 2, 2016.**</b> <b>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? LPN#1 is no longer employed with this company as of February 29, 2016. How other residents having the potential to be affected by the same deficient practice will be</b></p>		04/11/2016

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	<p>diagnoses included, but were not limited to, high blood pressure, stroke, and chronic kidney disease.</p> <p>A review of Resident #D's Advance Directives dated 1-24-2016 indicated Resident #D wished to have CPR performed. (Full code)</p> <p>A review of physician's orders dated 2-2016 indicated Resident #D was to have CPR performed.</p> <p>In an interview on 3-15-2016 at 3:22 PM, CNA #2 indicated LPN #1 had informed her Resident #D had been found breathless, pulseless, and cold at about 6:45 AM. CNA #2 indicated she had asked LPN #1 what they were going to do, and LPN #1 indicated to CNA #2, "We are going to let day shift worry about it". CNA #2 indicated she was not CPR certified, and could be of no help. So, she reasoned, the resident must have been a Do Not Resuscitate (DNR). When she heard Resident #D was a full code, she reported the incident for investigation.</p> <p>A review of LPN #1's employee file on 3-15-2016 at 1:52 PM indicated LPN #1 was CPR certified, and the certification was current until 3-31-2016.</p>		<p><b>identified and what corrective action(s) will be taken?</b> There were 7 residents who would have had the potential for being affected. <b>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?</b></p> <ol style="list-style-type: none"> <li>1.All licensed nurses have current CPR certifications.</li> <li>2.All licensed nurses will be in-serviced on a new policy for Cardiopulmonary Resuscitation during the weeks of April 1, 2016-April 11, 2016. Any licensed nurses on a leave of absence will be in-serviced on the first day that they return to work.</li> <li>3.All resident charts were audited to ensure that the resident code status was current on each residents nursing care plan on March 5, 2016.</li> <li>4.The nurses 24 hour report sheet was audited to ensure all resident code status is current to each resident chart on March 7, 2016.</li> <li>5.Revised CPR policy and procedure on April 1, 2016. <b>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance will be put into place?</b></li> </ol> <ol style="list-style-type: none"> <li>1.The DON/ADON or designee will monitor the code status of each resident chart weekly x one month.</li> <li>2.The DON/ADON or designee will audit the records for code</li> </ol>	

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	<p>A review of nurse's progress notes did not indicate LPN #1 had documented her assessment of the resident.</p> <p>In an interview on 3-15-2016 at 10:47 AM, RN #3 indicated she was CPR certified, and when she came in on day shift the day of the incident, the night shift nurse reported to her the resident was fine. When therapy entered the room at about 7:45 AM, they came to her, and told her Resident #D was not breathing. RN#3 indicated her assessment was Resident #D was cold, stiff, and had obvious lividity. She further indicated she knew Resident #D was a full code, but following policy, she called the physician to report her findings, and was instructed by the physician to not begin CPR.</p> <p>In an interview on 3-16-2016 at 11:57 AM, PTA #4 indicated when the room was entered, Resident #D had obvious lividity, was stiff, and his eyes were sunken. Further, PTA #4 indicated Resident #D was cold to touch. She further indicated when the nurse was notified, RN #3 assessed the resident and promptly called the physician according to the policy.</p> <p>A current policy dated March 2015 titled Emergency procedure- Cardiopulmonary Resuscitation provided by the</p>		<p>status of each resident every month x 5 months.</p> <p>3.If a resident death would occur, the DON/ADON or designee will audit the resident chart to ensure the documentation is complete and that it follows the policy and procedure of the facility to ensure physician notification, family notification and that advanced directives were followed.</p> <p>4. The QA committee will review the results of the findings during the facility's Quality Assurance meeting for at least 6 months. At the end of the aforementioned 6 month period, the committee may opt to discontinue the review of this data during the QA meetings if compliance is evident.</p>	

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	<p>Administrator on 3-15-2016 at 10:46 AM indicated "6. If an individual is found unresponsive and not breathing normally, a licensed staff member who is certified in CPR/ BLS shall initiate CPR unless: b. there are obvious signs of irreversible death (e.g.. rigor mortis)"</p> <p>In an interview on 3-15-2016 at 11:20 AM, the Administrator indicated LPN #1 should have called the physician for further direction.</p> <p>This Federal Citation is related to Complaint IN00194866.</p> <p>3.1-4(d)</p>						
F 0157 SS=D Bldg. 00	<p>483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial</p>						

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	<p>status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).</p> <p>The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.</p> <p>The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.</p> <p>Based on interview and record review, the facility failed to notify the physician in a timely manner of a change in resident condition for 1 of 3 residents reviewed with a change in condition in a sample of 3. (Resident #D)</p> <p>Findings include:</p> <p>Resident #D's record was reviewed 3-15-2016 at 3:14 PM. Resident #D's diagnoses included, but were not limited to, high blood pressure, stroke, and chronic kidney disease.</p>	F 0157	<p><b>**The facility self-reported this complaint to Indiana State Department of Health prior to this survey on March 2, 2016.**</b></p> <p><b>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? LPN#1 is no longer employed with this company as of February 29, 2016. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken? There were 7 residents who would have had the potential for being</b></p>	04/11/2016

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	<p>A review of Resident #D's Advance Directives dated 1-24-2016 indicated Resident #D wished to have CPR performed.</p> <p>A review of physician's orders dated 2-2016 indicated Resident #D was to have CPR performed.</p> <p>In an interview on 3-15-2016 at 3:22 PM, CNA #2 indicated LPN #1 had informed her Resident #D had been found breathless, pulseless, and cold at about 6:45 AM. CNA #2 indicated she had asked LPN #1 what they were going to do, and LPN #1 indicated to CNA #2, "We are going to let day shift worry about it". CNA #2 indicated she was not CPR certified, and could be of no help. So, she reasoned, the resident must have been a Do Not Resuscitate (DNR). When she heard Resident #D was a full code, she reported the incident for investigation. CNA #2 further indicated she did not witness LPN #1 calling the physician or the family.</p> <p>A review of nurse's progress notes did not indicate LPN #1 had documented her assessment of the resident.</p> <p>In an interview on 3-15-2016 at 10:47 AM, RN #3 indicated she was CPR certified, and when she came in on day</p>		<p>affected. <b>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?</b></p> <p>1.All licensed nurses will be in-serviced on reporting and documenting the change of condition to the MD/NP and the resident's responsible party during the week of April 7, 2016-April 11, 2016. Any licensed nurses on a leave of absence will be in-serviced on the first day that they return to work.</p> <p>2.All licensed nurses will be in-serviced on change in a resident's condition or status.</p> <p><b>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance will be put into place?</b></p> <p>1.DON/ADON or designee will audit all charts daily for 14 days for change of condition to ensure proper notification to the resident's MD/NP and their responsible party.</p> <p>2.DON/ADON or designee will audit all charts 2 x a week for 14 days for change of condition to ensure proper notification to the resident's MD/NP and their responsible party.</p> <p>3.DON/ADON or designee will audit weekly for 5 ½ months to ensure proper notification to the resident's MD/NP and their responsible party.</p> <p>4. The QA committee will review the results of the findings during</p>				

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	<p>shift the day of the incident, the night shift nurse reported to her the resident was fine. When therapy entered the room at about 7:45 AM, they came to her, and told her Resident #D was not breathing. RN#3 indicated her assessment was Resident #D was cold, stiff, and had obvious lividity. She further indicated she knew Resident #D was a full code, but following policy, she called the physician to report her findings, and was instructed to not begin CPR.</p> <p>In an interview on 3-16-2016 at 11:57 AM, PTA #4 indicated when the room was entered, Resident #D had obvious lividity, was stiff, and his eyes were sunken. Further, PTA #4 indicated Resident #D was cold to touch. She further indicated when the nurse was notified, RN #3 assessed the resident and promptly called the physician according to the policy.</p> <p>In an interview on 3-15-2016 at 11:20 AM, the Administrator indicated LPN #1 should have called the physician.</p> <p>This Federal Citation is related to Complaint IN00194866.</p> <p>3.1-5(a)(2)</p>		<p>the facility's Quality Assurance meeting for at least 6 months. At the end of the aforementioned 6 month period, the committee may opt to discontinue the review of this data during the QA meetings if compliance is evident.</p>				

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F 0241 SS=D Bldg. 00	<p>483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.</p> <p>Based on observation, and interview, the facility failed to provide dignity for 1 of 3 residents reviewed for dignity in a sample of 3, (Resident #D)</p> <p>Findings include:</p> <p>Resident #D's record was reviewed 3-15-2016 at 3:14 PM. Resident #D's diagnoses included, but were not limited to, high blood pressure, stroke, and chronic kidney disease.</p> <p>In an interview on 3-15-2016 at 3:22 PM, CNA #2 indicated LPN #1 had informed her Resident #D had been found breathless, pulseless, and cold at about 6:45 AM. CNA #2 indicated she had asked LPN #1 what they were going to do, and LPN #1 indicated to CNA #2, "We are going to let day shift worry about it".</p>	F 0241	<p><b>**The facility self-reported this complaint to Indiana State Department of Health prior to this survey on March 2, 2016.**</b></p> <p><b>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</b> LPN#1 is no longer employed with this company as of February 29, 2016. <b>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken?</b> All residents have the potential for being affected. <b>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?</b> An in-service will be held during the week of April 7, 2016-April 11, 2016 on dignity and respect. Any staff on a leave of absence will be in-serviced on the first day that they return to work. <b>How the</b></p>	04/11/2016

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	<p>In an interview on 3-15-2016 at 10:47 AM, RN #3 indicated when she came in at 7 AM on day shift the day of the incident, the night shift nurse reported to her the resident was fine. She further indicated the door to Resident #D's room was shut, and she did not enter as she would be entering in a few minutes with medications for Resident #D. RN #3 further indicated post mortem care was to be given as soon as possible after death.</p> <p>In an interview on 3-16-2016 at 11:57 AM, PTA #4 indicated the room door was shut, and so, she knocked and entered at about 7:45 AM, she found Resident #D with obvious lividity, stiffness, and sunken eyes. Further, PTA #4 indicated Resident #D was cold to touch. PTA #4 indicated she told the day nurse immediately and the day nurse assessed Resident #D and called the physician and the family.</p> <p>On 3-15-2016 at 3:48 PM a review of the videotape dated 2-25-2016 indicated at about 4:30 AM, Resident #D's roommate was wandering and fidgety. CNA #2 took him to the Resident Lounge and gave him a snack. Resident #D's roommate is seen on the tape sitting in the lounge, and wandering, but not going back into the room. At about 6:42 AM, LPN #1</p>		<p><b>corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance will be put into place?</b></p> <p>1. DON/ADON or designee will monitor daily x 14 days if any resident is near death or if death has occurred that privacy will be provided for that resident.</p> <p>2. DON/ADON or designee will monitor for 5 ½ months that if any resident is near death or if death has occurred that privacy will be provided for that resident.</p> <p>3. The QA committee will review the results of the findings during the facility's Quality Assurance meeting for at least 6 months. At the end of the aforementioned 6 month period, the committee may opt to discontinue the review of this data during the QA meetings if compliance is evident.</p>	

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F 0281 SS=D Bldg. 00	<p>entered Resident #D's room, and about 6:45 AM, exiting Resident #D's room, shutting the door. There was no assurance Resident #D's roommate would not reenter the room.</p> <p>In an interview on 3-16-2016 at 1:22 PM, the Administrator indicated residents deserve to be treated with dignity and respect. She further indicated LPN #1 did not treat Resident #D with dignity and respect.</p> <p>This Federal Citation is related to Complaint IN00194866.</p> <p>3.1-3(t)</p> <p>483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality.</p> <p>Based on interview and record review, the facility failed to ensure professional quality was maintained with a change in resident condition for 1 of 3 residents reviewed in a sample of 3. (Resident #D)</p> <p>Findings include:</p>	F 0281	<p><b>**The facility self-reported this complaint to Indiana State Department of Health prior to this survey on March 2, 2016.**</b></p> <p><b>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? LPN#1 is no longer employed with this company as of</b></p>	04/11/2016

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	<p>Resident #D's record was reviewed 3-15-2016 at 3:14 PM. Resident #D's diagnoses included, but were not limited to, high blood pressure, stroke, and chronic kidney disease.</p> <p>A review of Resident #D's Advance Directives dated 1-24-2016 indicated Resident #D wished to have CPR performed.</p> <p>A review of physician's orders dated 2-2016 indicated Resident #D was to have CPR performed.</p> <p>In an interview on 3-15-2016 at 3:22 PM, CNA #2 indicated LPN #1 had informed her Resident #D had been found breathless, pulseless, and cold at about 6:45 AM. CNA #2 indicated she had asked LPN #1 what they were going to do, and LPN #1 indicated to CNA #2, "We are going to let day shift worry about it". CNA #2 indicated she was not CPR certified, and could be of no help. So, she reasoned, the resident must have been a Do Not Resuscitate (DNR). When she heard Resident #D was a full code, she reported the incident for investigation.</p> <p>A review of LPN #1's employee file on 3-15-2016 at 1:52 PM indicated LPN #1</p>		<p>February 29, 2016. <b>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken?</b> There are 7 residents who have the potential for being affected.</p> <p><b>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?</b></p> <ol style="list-style-type: none"> <li>1. Our policy on Cardiopulmonary resuscitation has been revised to meet the guidelines of the American Heart Association for CPR.</li> <li>2. An in-service will be held the week of April 7, 2016-April 11, 2016 for all nursing personnel. Any nursing staff on a leave of absence will be in-serviced on the first day that they return to work.</li> <li>3. All QMAs and CNAs will be checked off on obtaining vital signs by April 11, 2016.</li> <li>4. Two nursing personnel will verify there are no vital signs and signs of rigor mortis is present (e.g. rigor mortis-lifeless, cold, stiffness, no temperature, no vital signs: no respirations-no lung sounds with stethoscope, no heart rate with stethoscope, and modeling in the sacral area if turn person to the side), dependent lividity, decapitation, transection or decomposition is present.</li> <li>5. The MD/NP will be notified by the licensed nurse for further instructions.</li> </ol>				

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	<p>was CPR certified, under American Heart Association Standards, and the certification was current until 3-31-2016.</p> <p>In an interview on 3-15-2016 at 10:47 AM, RN #3 indicated she was CPR certified, and when she came in on day shift the day of the incident, the night shift nurse reported to her the resident was fine. When therapy entered the room at about 7:45 AM, they came to her, and told her Resident #D was not breathing. RN#3 indicated her assessment was Resident #D was cold, stiff, and had obvious lividity. She further indicated she knew Resident #D was a full code, but following policy, she called the physician to report her findings, and was instructed to not begin CPR.</p> <p>In an interview on 3-16-2016 at 11:57 AM, PTA #4 indicated when the room was entered, Resident #D had obvious lividity, was stiff, and his eyes were sunken. Further, PTA #4 indicated Resident #D was cold to touch. She further indicated when the nurse was notified, RN #3 assessed the resident and promptly called the physician according to the policy.</p> <p>A current policy dated March 2015 titled Emergency procedure- Cardiopulmonary Resuscitation provided by the</p>		<p><b>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance will be put into place?</b></p> <ol style="list-style-type: none"> <li>1. DON/ADON or designee will audit all charts 2 x a week for 14 days if death occurs that the MD/NP is notified.</li> <li>2. DON/ADON or designee will audit for 5 ½ months to ensure the MD/NP is notified at the time of death for further instructions.</li> <li>3. The QA committee will review the results of the findings during the facility's Quality Assurance meeting for at least 6 months. At the end of the aforementioned 6 month period, the committee may opt to discontinue the review of this data during the QA meetings if compliance is evident.</li> </ol>	

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	<p>Administrator on 3-15-2016 at 10:46 AM indicated "6. If an individual is found unresponsive and not breathing normally, a licensed staff member who is certified in CPR/ BLS shall initiate CPR unless: b. there are obvious signs of irreversible death (e.g.. rigor mortis)"</p> <p>In an interview on 3-15-2016 at 11:20 AM, the Administrator indicated LPN #1 should have called the physician for further guidance.</p> <p>A review of Indiana Law indicated an LPN cannot declare death. It is the duty of the LPN to gather the information regarding resident status, vital signs, and condition, but must call physician, relay the information and follow the physician's directives.</p> <p>According to the American heart Association guidelines for CPR, available at <a href="http://eccguidelines.heart.org">eccguidelines.heart.org</a>, Part three, CPR may be withheld if there are "obvious signs of irreversible death such as rigor mortis, dependant lividity, decapitation, transection, or decomposition."</p> <p>This Federal Citation is related to Complaint IN00194866.</p> <p>3.1-35(g)(1)</p>			

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F 0514 SS=D Bldg. 00	<p>483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCE SSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.</p> <p>The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.</p> <p>Based on interview and record review, the facility failed to ensure records were complete for 1 of 3 residents reviewed for complete records in a sample of 3. (Resident #D)</p> <p>Findings include:</p> <p>Resident #D's record was reviewed 3-15-2016 at 3:14 PM. Resident #D's diagnoses included, but were not limited to, high blood pressure, stroke, and chronic kidney disease.</p>	F 0514	<p><b>**The facility self-reported this complaint to Indiana State Department of Health prior to this survey on March 2, 2016.**</b></p> <p><b>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</b> LPN#1 is no longer employed with this company as of February 29, 2016. <b>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken?</b> There were 7 residents who would have had the potential for being</p>	04/11/2016

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	<p>In an interview on 3-15-2016 at 3:22 PM, CNA #2 indicated LPN #1 had informed her Resident #D had been found breathless, pulseless, and cold at about 6:45 AM. CNA #2 indicated she had asked LPN #1 what they were going to do, and LPN #1 indicated to CNA #2, "We are going to let day shift worry about it". CNA #2 indicated she was not CPR certified, and could be of no help. So, she reasoned, the resident must have been a Do Not Resuscitate (DNR). When she heard Resident #D was a full code, she reported the incident for investigation.</p> <p>A review of nurse's progress notes did not indicate LPN #1 had documented any of her assessment of the resident.</p> <p>In an interview on 3-15-2016 at 10:47 AM, RN #3 indicated she was CPR certified, and when she came in on day shift the day of the incident, the night shift nurse reported to her the resident was fine. When therapy entered the room at about 7:45 AM, they came to her, and told her Resident #D was not breathing. RN#3 indicated her assessment was Resident #D was cold, stiff, and had obvious lividity. She further indicated she knew Resident #D was a full code, but following policy, she called the physician to report her findings, and was instructed</p>		<p>affected. <b>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?</b></p> <p>1.All licensed nurses will be in-serviced on reporting and documenting change of condition to the MD/NP and the responsible party during the week of April 7, 2016-April 11, 2016.</p> <p>2.All licensed nurses will be in-serviced on charting and documentation during the week of April 7, 2016-April 11, 2016. Any licensed nurses on a leave of absence will be in-serviced on the first day that they return to work.</p> <p><b>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance will be put into place?</b></p> <p>1.DON/ADON or designee will audit all charts daily x 14 days for change of condition and proper documentation to ensure proper notification to the resident's MD/NP and their responsible party.</p> <p>2.DON/ADON or designee will audit all charts 2 x a week for 14 days for change of condition to ensure proper notification to the resident's MD/NP and their responsible party.</p> <p>3.DON/ADON or designee will audit weekly for 5 ½ months to ensure proper notification to the resident's MD/NP and their responsible party.</p> <p>4. The QA committee will review</p>				

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	<p>to not begin CPR. RN #3 indicated LPN #1 should have documented her assessment of the resident.</p> <p>In an interview on 3-15-2016 at 11:20 AM, the Administrator indicated LPN #1 should have documented her assessment of Resident #D.</p> <p>This Federal Citation is related to Complaint IN00194866.</p> <p>3.1-50(a)(1)</p>		<p>the results of the findings during the facility's Quality Assurance meeting for at least 6 months. At the end of the aforementioned 6 month period, the committee may opt to discontinue the review of this data during the QA meetings if compliance is evident.</p>		